1.1 .... moves to amend H.F. No. 4338, the first engrossment, as follows:

1.2 Page 3, after line 29, insert:

1.3 "Sec. .... Minnesota Statutes 2024, section 144.292, subdivision 6, is amended to read:

1.4 Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of
1.5 reviewing current medical care, the provider must not charge a fee.

1.6 (b) When a provider or its representative makes copies of patient records upon a patient's
1.7 request under this section, the provider or its representative may charge the patient or the
1.8 patient's representative no more than the following amount, unless other law or a rule or
1.9 contract provide for a lower maximum charge:

1.10 (1) for paper copies, $1 per page, plus $10 for time spent retrieving and copying the
1.11 records;

1.12 (2) for x-rays, a total of $30 for retrieving and reproducing x-rays; and

1.13 (3) for electronic copies, a total of $20 for retrieving the records.

1.14 (c) For any copies of paper records provided under paragraph (b), clause (1), a provider
1.15 or the provider's representative may not charge more than a total of:

1.16 (1) $10 if there are no records available;

1.17 (2) $30 for copies of records of up to 25 pages;

1.18 (3) $50 for copies of records of up to 100 pages;

1.19 (4) $50, plus an additional 20 cents per page for pages 101 and above; or

1.20 (5) $500 for any request.

1.21 (d) A provider or its representative may charge a $10 retrieval fee, but must not charge
1.22 a per page fee or x-ray fee to provide copies of records requested by a patient or the patient's

2.1 authorized representative if the request for copies of records is for purposes of appealing a
2.2 denial of Social Security disability income or Social Security disability benefits under title
2.3 II or title XVI of the Social Security Act or for purposes of a disability determination by
2.4 the department's state medical review team. Notwithstanding the foregoing, a provider or
2.5 its representative must not charge a fee, including a retrieval fee, to provide copies of records
2.6 requested by a patient or the patient's authorized representative if the request for copies of
2.7 records is for purposes of appealing a denial of Social Security disability income or Social
2.8 Security disability benefits under title II or title XVI of the Social Security Act or for purposes
2.9 of a disability determination by the department's state medical review team when the patient
2.10 is receiving public assistance, represented by an attorney on behalf of a civil legal services
2.11 program, or represented by a volunteer attorney program based on indigency. The patient
2.12 or the patient's representative must submit one of the following to show that they are entitled
2.13 to receive records without charge under this paragraph:

2.14 (1) a public assistance statement from the county or state administering assistance;

2.15 (2) a request for records on the letterhead of the civil legal services program or volunteer
2.16 attorney program based on indigency; or

2.17 (3) a benefits statement from the Social Security Administration.

2.18 For the purpose of further appeals, a patient may receive no more than two medical record
2.19 updates without charge, but only for medical record information previously not provided.

2.20 For purposes of this paragraph, a patient's authorized representative does not include units
2.21 of state government engaged in the adjudication of Social Security disability claims.

2.22 **EFFECTIVE DATE.** This section is effective the day following final enactment."

2.23 Page 4, after line 5, insert:

2.24 "Sec. .... Minnesota Statutes 2024, section 245.4711, subdivision 5, is amended to read:

2.25 Subd. 5. **Coordination between case manager and community support services.** (a)
2.26 The county board must establish procedures that ensure ongoing contact and coordination
2.27 between the case manager and the community support services program as well as other
2.28 mental health services.

2.29 (b) At a minimum, the case manager must have at least one case management contact
2.30 with a documented core service component, as defined by the commissioner, to claim
2.31 reimbursement for adult mental health targeted case management. Adult mental health case
2.32 managers must not conduct the required case management contact by telephone with the

3.1 adult client or the adult client's legal representative for more than two consecutive calendar
3.2 months.

3.3 Sec. .... Minnesota Statutes 2024, section 245.4881, subdivision 5, is amended to read:

3.4 Subd. 5. **Coordination between case manager and family community support**
3.5 **services.** (a) The county board must establish procedures that ensure ongoing contact and
3.6 coordination between the case manager and the family community support services as well
3.7 as other mental health services for each child.

3.8 (b) At a minimum, the case manager must have at least one contact in every calendar
3.9 month, conducted in person or by interactive video that meets the requirements of section
3.10 256B.0625, subdivision 20b, with the child, the child's parents, or the child's legal
3.11 representative."

3.12 Page 14, after line 11, insert:

3.13 "Sec. .... Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
3.14 to read:

3.15 Subd. 4a. **Case management contact.** "Case management contact" means interactive
3.16 communication conducted either in person, by interactive video that meets the requirements
3.17 of section 256B.0625, subdivision 20b, or by telephone with the client; client's parent; legal
3.18 guardian, guardian ad litem, or attorney for clients that are children or youth under 19 years
3.19 of age; or client's attorney for clients that are adults 19 years of age or older."

3.20 Page 26, after line 9, insert:

3.21 "Subd. 4. **Termination for lack of submitted claims.** The commissioner may terminate
3.22 the enrollment of an individual provider or an entity provider if the individual provider or
3.23 entity provider has not submitted any claims in the previous 12 consecutive calendar months."

3.24 Page 30, line 8, after "as" insert "moderate-risk or"

3.25 Page 30, line 13, delete "new" and before the period, insert "for the first time"

3.26 Page 30, line 21, delete everything after "under" and insert "this section within 15 days
3.27 of a provider, covered service, or fee-for-service claim being subject to review under
3.28 subdivision 2."

3.29 Page 30, delete lines 22 to 23

3.30 Page 31, line 1, before "service" insert "covered"

Page 31, line 13, before "claims" insert "fee-for-service"

Page 31, line 25, delete "may" and insert "must"

Page 31, line 26, delete "up to"

Page 32, line 1, delete "Claims" and insert "Fee-for-service claims" and delete "furnished" and insert "provided"

Page 32, line 11, delete "the" and insert "a list of"

Page 38, before line 1, insert:

"Sec. .... Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with serious mental illness. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with serious mental illness when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, ~~excluding subparts 6 and 10~~ subpart 9.

(c) Medical assistance and MinnesotaCare payment for mental health case management ~~shall~~ must be made ~~on a monthly basis~~ in accordance with section 256B.076, subdivisions 1, 2, 5, and 7. ~~In order to receive payment for an eligible child, the provider must document at least a face-to-face contact either in person or by interactive video that meets the requirements of subdivision 20b with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:~~

~~(1) at least a face-to-face contact with the adult or the adult's legal representative either in person or by interactive video that meets the requirements of subdivision 20b; or~~

~~(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact either in person or by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.~~

(d) Payment for mental health case management provided by county or state staff ~~shall~~ must be based on the ~~monthly~~ rate methodology under section ~~256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults~~ 256B.076, subdivisions 5 and 7.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county must be calculated in accordance with section 256B.076, subdivision 2. Payment for mental health case management provided by vendors who contract with a Tribe must be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

6.1 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
6.2 that does not meet the ~~reporting or other~~ requirements of this section or sections 245.4711,
6.3 245.4881, 256B.0924, 256B.094, and 256F.10. The county of responsibility, as defined in
6.4 sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any
6.5 federal disallowances. The county or tribe may share this responsibility with its contracted
6.6 vendors.

6.7 (k) The commissioner shall set aside a portion of the federal funds earned for county
6.8 expenditures under this section to repay the special revenue maximization account under
6.9 section 256.01, subdivision 2, paragraph (n). The repayment is limited to:

6.10 (1) the costs of developing and implementing this section; and

6.11 (2) programming the information systems.

6.12 (l) Payments to counties and tribal agencies for case management expenditures under
6.13 this section shall only be made from federal earnings from services provided under this
6.14 section. When this service is paid by the state without a federal share through fee-for-service,
6.15 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
6.16 shall include the federal earnings, the state share, and the county share.

6.17 (m) Case management services under this subdivision do not include therapy, treatment,
6.18 legal, or outreach services.

6.19 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
6.20 and the recipient's institutional care is paid by medical assistance, payment for case
6.21 management services under this subdivision is limited to the lesser of:

6.22 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
6.23 than six months in a calendar year; or

6.24 (2) the limits and conditions which apply to federal Medicaid funding for this service.

6.25 (o) Payment for case management services under this subdivision shall not duplicate
6.26 payments made under other program authorities for the same purpose.

6.27 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
6.28 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
6.29 mental health targeted case management services must actively support identification of
6.30 community alternatives for the recipient and discharge planning.

6.31 (q) Counties may receive payment for up to 12 15-minute units for use at case initiation
6.32 and case closing to facilitate the case management client's needs assessments, individualized

7.1 plan development, referrals, or case documentation without needing to meet the contact
7.2 requirements specified in sections 245.4711, 245.4881, 256B.0924, 256B.094, and 256F.10."

7.3 Page 44, line 8, delete "information" and insert "informations"

7.4 Page 55, after line 25, insert:

7.5 "Sec. .... Minnesota Statutes 2024, section 256B.198, is amended to read:

7.6 **256B.198 PAYMENTS FOR NON-HOSPITAL-BASED GOVERNMENTAL**
7.7 **HEALTH CENTERS.**

7.8 (a) The commissioner may make payments to non-hospital-based health centers operated
7.9 by a governmental entity for the difference between the expenditures incurred by the health
7.10 center for patients eligible for medical assistance, and the payments to the health center for
7.11 medical assistance permitted elsewhere under this chapter.

7.12 (b) The nonfederal share of payments authorized under paragraph (a) shall be provided
7.13 through certified public expenditures authorized under section 256B.199, paragraph (b).

7.14 (c) Effective July 1, 2013, or no earlier than 12 months after implementation of a total
7.15 cost of care demonstration project, Hennepin County may receive federal matching funds
7.16 for certified public expenditures under paragraph (a), if the county participates in a total
7.17 cost of care demonstration project under sections 256B.0755 and 256B.0756, or another
7.18 total cost of care demonstration project approved by the commissioner, and the county
7.19 exceeds the minimum performance threshold established by the commissioner for the
7.20 demonstration project. The value of the federal matching funds for the certified public
7.21 expenditures allocated to Hennepin County shall be equal to the value of savings achieved
7.22 above the minimum performance threshold. The same proportion of federal matching funds
7.23 for certified public expenditure allocated to Hennepin County based on savings achieved
7.24 under the demonstration project shall continue after the demonstration project and must
7.25 continue to be paid to Hennepin County each year thereafter.

7.26 (d) Beginning July 1, 2014, or no earlier than 12 months after the initial allocation under
7.27 paragraph (c) if a portion of the federal matching funds for certified public expenditure
7.28 remains with the state, the commissioner shall annually determine if the savings from
7.29 county's total cost of care demonstration project exceeded the savings from the previous
7.30 year and allocate federal matching funds for certified public expenditures to Hennepin
7.31 County equal to the amount of savings achieved above the amount achieved in the previous
7.32 year. The proportion of federal matching funds for certified public expenditure allocated to

8.1 Hennepin County shall be paid to Hennepin County each year thereafter, until no federal
8.2 matching funds for certified public expenditures under paragraph (a) remain with the state.

8.3 (e) Nothing under this section precludes Hennepin County from receiving an additional
8.4 gain-sharing payment or relieves the county from paying a downside risk-sharing payment
8.5 to the state under the demonstration project under section 256B.0755.

8.6 (f) Payments under this section expire June 30, 2026."

8.7 Page 52, after line 18, insert:

8.8 "Sec. .... Minnesota Statutes 2024, section 256B.076, subdivision 1, is amended to read:

8.9 Subdivision 1. **Generally.** (a) It is the policy of this state to ensure that individuals on
8.10 medical assistance receive cost-effective and coordinated care, including efforts to address
8.11 the profound effects of housing instability, food insecurity, and other social determinants
8.12 of health. Therefore, subject to federal approval, medical assistance covers targeted case
8.13 management services as described in this section and sections 245.4711, 245.4881,
8.14 256B.0625, subdivisions 20 to 20b, 256B.0924, 256B.094, and 256F.10.

8.15 (b) The commissioner, in collaboration with Tribes, counties, providers, and individuals
8.16 served, must propose further modifications to targeted case management services to ensure
8.17 a program that complies with all federal requirements, delivers services in a cost-effective
8.18 and efficient manner, creates uniform expectations for targeted case management services,
8.19 addresses health disparities, and promotes person- and family-centered services.

8.20 (c) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
8.21 that does not meet the requirements of this section or sections 245.4711, 245.4881,
8.22 256B.0625, subdivisions 20 and 20b, 256B.0924, 256B.094, and 256F.10. The county of
8.23 financial responsibility, as determined under sections 256G.01 to 256G.12 or, if applicable,
8.24 the Tribal agency, is responsible for any federal disallowances. The county or Tribal agency
8.25 may share the financial responsibility with the county's or Tribal agency's contracted vendors.

8.26 Sec. .... Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
8.27 to read:

8.28 Subd. 5. **County-provided fee-for-service rate setting and reconciliation.** (a) Effective
8.29 January 1 of the implementation year determined under subdivision 6, or upon federal
8.30 approval, whichever is later, the commissioner must pay targeted case management services
8.31 for which counties provide the nonfederal share of money and county staff provide the
8.32 services on a fee-for-service basis according to the cost-based payment methodology in this

9.1 subdivision and consistent with the federal regulations related to certified public expenditures.
9.2 To receive federal reimbursement for these services, a county providing eligible forms of
9.3 targeted case management services must complete a federally approved cost report, in
9.4 accordance with section 256.01, subdivision 2, paragraph (o).

9.5 (b) The commissioner must reimburse submitted claims based on an interim rate and
9.6 must determine a final rate on a calendar-year basis following completion of a cost report
9.7 reconciliation. The commissioner must notify counties of the final rate and post final rates
9.8 publicly.

9.9 (c) A county has 60 days to appeal a final rate. To appeal a final rate, a county must
9.10 submit a written appeal request to the commissioner within 60 days of the date the
9.11 commissioner issued the final rate determination. The appeal request shall specify (1) the
9.12 disputed items, and (2) the name and address of the person to contact regarding the appeal.

9.13 (d) The payment methodology under this section must only be used to reimburse
9.14 allowable Medicaid costs. The county of financial responsibility, as determined under
9.15 sections 256G.01 to 256G.12, is responsible for any federal disallowances.

9.16 (e) Upon implementation, the commissioner must base interim rates on data from the
9.17 testing period. The commissioner must base subsequent interim rates for a calendar year
9.18 on the most recently completed reconciliation. The commissioner must notify counties of
9.19 the interim rate by June 30 each year and post interim rates publicly. If the commissioner
9.20 is unable to notify the counties by June 30, the commissioner must notify each county in
9.21 writing no later than June 30 that the new interim rate is delayed and must provide an
9.22 estimate of when the new interim rate will be available.

9.23 (f) Payments to counties for case management expenditures under this section must be
9.24 made only from federal earnings from services provided under this section.

9.25 (g) Counties must submit all claims for targeted case management services described
9.26 in this section using a 15-minute unit.

9.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

9.28 Sec. .... Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
9.29 to read:

9.30 Subd. 6. **Testing and implementation.** The commissioners of human services and
9.31 children, youth, and families; the Association of Minnesota Counties (AMC); and the
9.32 Minnesota Association of County Social Service Administrators (MACSSA) must collaborate
9.33 to establish a joint governance agreement that must:

10.1 (1) establish system functionality requirements to meet the business needs of local
10.2 agencies providing targeted case management services and comply with applicable state
10.3 and federal regulations for the Social Services Information System (SSIS), SSIS's
10.4 replacement, and adjacent systems and the target case management cost report under
10.5 subdivision 5;

10.6 (2) establish a schedule for transition planning, including but not limited to fiscal impact
10.7 assessment and training; and

10.8 (3) specify that the rate method established in subdivision 5 must not be implemented
10.9 without both the completion of the required testing period of 12 calendar months and the
10.10 expressed approval by the commissioners of human services and children, youth, and
10.11 families; AMC; and MACSSA.

10.12 Sec. .... Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
10.13 to read:

10.14 Subd. 7. **Managed care plan units and rates for mental health targeted case**
10.15 **management.** The commissioner must ensure that the prepaid health plans providing covered
10.16 health services for eligible persons pursuant to this chapter and chapter 256L reimburse
10.17 counties at a rate that is at least equal to the fee-for-service rate described in subdivision 5
10.18 for targeted case management services provided to Minnesota health care program (MHCP)
10.19 health plan enrollees covered by medical assistance. If, for any contract year, federal approval
10.20 is not received for this subdivision, the commissioner must adjust the capitation rates paid
10.21 to managed care plans and county-based purchasing plans for that contract year to reflect
10.22 the removal of this subdivision. Contracts between managed care plans and county-based
10.23 purchasing plans and providers to whom this subdivision applies must allow recovery of
10.24 payments from those providers if capitation rates are adjusted in accordance with this
10.25 subdivision. Payment recoveries must not exceed the amount equal to any increase in rates
10.26 that results from this subdivision. This subdivision expires if federal approval is not received
10.27 for this subdivision at any time. This subdivision does not obligate MHCP health plans to
10.28 contract with counties for the provision of targeted case management services.

10.29 **EFFECTIVE DATE.** This section is effective January 1, 2027.

10.30 Sec. .... Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
10.31 to read:

10.32 Subd. 8. **Targeted case management gap funding.** (a) For purposes of this subdivision,
10.33 "unacceptable loss" means when a county's finalized amount of targeted case management

federal reimbursement following the commissioner's reconciliation for a calendar year for targeted case management under subdivision 5 is less than 90 percent of the average federal reimbursement received by that county during the base calendar years determined in paragraph (c).

(b) The commissioner must pay targeted case management gap funding in the amount and time frame specified in paragraph (c) to an individual county for calendar years in which the county experiences an unacceptable loss.

(c) The base calendar years are the three calendar years immediately before the testing period of 12 calendar months determined under subdivision 6. In consultation with the county that experienced the unacceptable loss, the commissioner must make appropriate adjustments to base year amounts as needed to prevent the base amounts from being unduly influenced by onetime events, anomalies, or small changes that appear large compared to a narrow historical base. The commissioner must not make adjustments to the eight county human services agencies that received the greatest amount of targeted case management federal reimbursement during the base calendar years. For agencies other than the eight county human services agencies that received the greatest amount, the total of all adjustments for a given calendar year must not exceed two percent of statewide federal targeted case management federal reimbursement that calendar year.

(d) The commissioner must pay targeted case management gap funding to the applicable county in an amount equaling the difference between the finalized amount of targeted case management federal reimbursement after reconciliation for that calendar year and 90 percent of the average federal reimbursement received by that county during the base calendar years, including any adjustments under paragraph (c). The commissioner must pay the county within 90 days of completing the reconciliation under subdivision 5.

(e) Targeted case management gap funding is a forecasted program under section 16A.11.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. .... Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **Payment for targeted case management.** (a) ~~Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult,~~ The provider must ~~document at least one contact per month and not more than two consecutive months without a face-to-face~~ meet the contact ~~either in person or~~ requirements under section 256B.094, subdivision 6. Contact

by interactive video ~~that meets~~ must meet the requirements in section 256B.0625, subdivision 20b, with the adult or the adult's legal representative, family, primary caregiver, or other relevant ~~persons~~ person identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Except as provided under paragraph (m), payment for targeted case management provided by county staff under this subdivision ~~shall~~ must be based on the ~~monthly~~ rate ~~methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001~~ established in section 256B.076, subdivisions 5 and 7. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate calculated in accordance with section 256B.076, subdivision 2. The rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(d) If the service is provided by a team that includes contracted vendors and county staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team targeted case management and a description of the different roles of the team members.

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of

13.1 responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal
13.2 disallowances. The county may share this responsibility with its contracted vendors.

13.3 (g) The commissioner shall set aside five percent of the federal funds received under
13.4 this section for use in reimbursing the state for costs of developing and implementing this
13.5 section.

13.6 (h) Payments to counties for targeted case management expenditures under this section
13.7 shall only be made from federal earnings from services provided under this section. Payments
13.8 to contracted vendors shall include both the federal earnings and the county share.

13.9 (i) Notwithstanding section 256B.041, county payments for the cost of case management
13.10 services provided by county staff shall not be made to the commissioner of management
13.11 and budget. For the purposes of targeted case management services provided by county
13.12 staff under this section, the centralized disbursement of payments to counties under section
13.13 256B.041 consists only of federal earnings from services provided under this section.

13.14 (j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
13.15 and the recipient's institutional care is paid by medical assistance, payment for targeted case
13.16 management services under this subdivision is limited to the lesser of:

13.17 (1) the last 180 days of the recipient's residency in that facility; or

13.18 (2) the limits and conditions which apply to federal Medicaid funding for this service.

13.19 (k) Payment for targeted case management services under this subdivision shall not
13.20 duplicate payments made under other program authorities for the same purpose.

13.21 (l) Any growth in targeted case management services and cost increases under this
13.22 section shall be the responsibility of the counties.

13.23 (m) The commissioner may make payments for Tribes according to section 256B.0625,
13.24 subdivision 34, or other relevant federally approved rate setting methodologies for vulnerable
13.25 adult and developmental disability targeted case management provided by Indian health
13.26 services and facilities operated by a Tribe or Tribal organization.

13.27 Sec. .... Minnesota Statutes 2024, section 256B.094, subdivision 2, is amended to read:

13.28 Subd. 2. **Eligible services.** Services eligible for medical assistance reimbursement
13.29 include:

13.30 (1) assessment of the recipient's need for case management services to gain access to
13.31 available medical, social, educational, economic support, and other related services;

14.1 (2) development, completion, and regular review of a written individual service plan
14.2 based on the assessment of need for case management services to ensure access to available
14.3 medical, social, educational, economic support, and other related services;

14.4 (3) routine contact or other communication with the client, the client's family, primary
14.5 caregiver, legal representative, substitute care provider, service providers, or other relevant
14.6 persons identified as necessary to the development or implementation of the goals of the
14.7 individual service plan, regarding the status of the client, the individual service plan, or the
14.8 goals for the client, exclusive of transportation of the child;

14.9 (4) coordinating referrals for, and the provision of, case management services for the
14.10 client with appropriate service providers, consistent with section 1902(a)(23) of the Social
14.11 Security Act;

14.12 (5) coordinating and monitoring the overall service delivery to ensure quality of services;

14.13 (6) monitoring and evaluating services on a regular basis to ensure appropriateness and
14.14 continued need based on the child's and family's or caregiver's current circumstances;

14.15 (7) completing and maintaining necessary documentation that supports and verifies the
14.16 activities in this subdivision;

14.17 (8) traveling to conduct a visit with the client or other relevant person necessary to the
14.18 development or implementation of the goals of the individual service plan; and

14.19 (9) coordinating with the medical assistance facility discharge planner in the 30-day
14.20 period before the client's discharge into the community. This case management service
14.21 provided to patients or residents in a medical assistance facility is limited to a maximum of
14.22 two 30-day periods per calendar year.

14.23 Sec. .... Minnesota Statutes 2024, section 256B.094, subdivision 3, is amended to read:

14.24 Subd. 3. **Coordination and provision of services.** (a) In a county or reservation where
14.25 a ~~prepaid medical assistance provider~~ managed care organization (MCO) or county-based
14.26 purchasing (CBP) plan has contracted under section 256B.69 to provide medical and mental
14.27 health services, the case management provider shall coordinate with the ~~prepaid provider~~
14.28 MCO or CBP plan to ensure that all necessary medical and mental health services required
14.29 under the contract are provided to recipients of case management services.

14.30 ~~(b) When the case management provider determines that a prepaid provider is not~~
14.31 ~~providing mental health services as required under the contract, the case management~~

~~provider shall assist the recipient to appeal the prepaid provider's denial pursuant to section 256.045, and may make other arrangements for provision of the covered services.~~

~~(c) The case management provider may bill the provider of prepaid health care services for any mental health services provided to a recipient of case management services which the county or tribal social services arranges for or provides and which are included in the prepaid provider's contract, and which were determined to be medically necessary as a result of an appeal pursuant to section 256.045. The prepaid provider must reimburse the mental health provider, at the prepaid provider's standard rate for that service, for any services delivered under this subdivision.~~

<u>(b) Child welfare targeted case management is carved out of Minnesota health care programs managed care contracts. The case management provider must assist the recipient to ensure access to all medically necessary services listed in section 256B.0625, whether delivered on a fee-for-service basis or by a MCO or CBP plan.</u>

~~(d)~~ <u>(c)</u> If the county or Tribal social services has not obtained prior authorization for this service, or an appeal results in a determination that the services were not medically necessary, the county or Tribal social services may not seek reimbursement from the prepaid provider.

Sec. .... Minnesota Statutes 2024, section 256B.094, subdivision 6, is amended to read:

Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical assistance reimbursement for services under this section ~~shall~~ <u>must</u> be made ~~on a monthly basis~~ <u>in accordance with section 256B.076</u>. Payment is based on face-to-face contacts either in person or by interactive video, or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the following requirements:

(1) there must be a face-to-face contact either in person or by interactive video that meets the requirements of section 256B.0625, subdivision 20b, at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by Tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of Children, section 260.93, and the placement in either case is more than 60 miles beyond

the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face, in-person contact.

~~(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482 and 256.01, subdivision 2, paragraph (o).~~

~~(c)~~ (b) Payments for Tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a Tribe or Tribal organization.

~~(d)~~ (c) Payment for case management provided by county contracted vendors must be calculated in accordance with section 256B.076, subdivision 2. Payment for case management provided by vendors who contract with a Tribe must be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged by the vendor for the same service to other payers. ~~If the service is provided by a team of contracted vendors, the team shall determine how to distribute the rate among its members.~~ No reimbursement received by contracted vendors shall be returned to the county or Tribal social services, except to reimburse the county or Tribal social services for advance funding provided by the county or Tribal social services to the vendor.

~~(e)~~ (d) If the service is provided by a team that includes contracted vendors and county or Tribal social services staff, the costs for county or Tribal social services staff participation in the team shall be included in the rate for county or Tribal social services provided services. In this case, the contracted vendor and the county or Tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

~~Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not~~

~~certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.~~

Sec. .... Minnesota Statutes 2024, section 256B.094, subdivision 7, is amended to read:

Subd. 7. ~~**Documentation for case record and claim**~~ **Service provision requirements.** (a) The assessment, case finding, and individual service plan shall be maintained in the individual case record under the Data Practices Act, chapter 13.

(b) Payment is based on face-to-face contacts either in person or by interactive video, or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. Contacts must meet the following requirements:

(1) in accordance with section 260C.212, subdivision 4a, and United States Code, title 42, section 622(b)(17), there must be a face-to-face contact either in person or by interactive video that meets the requirements of section 256B.0625, subdivision 20b, at least once a month, except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by Tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or according to the Interstate Compact for the Placement of Children under section 260.93, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face, in-person contact.

(c) The individual service plan must be reviewed at least annually and updated as necessary. Each individual case record must maintain documentation of routine, ongoing, contacts and services. Each claim must be supported by written documentation in the individual case record.

~~(b)~~ (d) Each claim must include:

(1) the name of the recipient;

(2) the date of the service;

(3) the name of the provider agency and the person providing service;

(4) the nature and extent of services; and

(5) the place of the services."

18.1 Page 99, delete section 25

18.2 Page 114, line 2, after the second comma, insert "family"

18.3 Page 117, line 18, after the second comma, insert "family"

18.4 Page 119, delete section 9

18.5 Page 121, after line 5, insert:

18.6 "Sec. .... Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision
18.7 to read:

18.8 Subd. 1a. **Direct payment.** For purposes of this section, "direct payment" means a
18.9 funding mechanism used by the commissioner to distribute state appropriations to a county
18.10 or Tribe for the purpose of carrying out duties, services, or activities authorized under this
18.11 section. A direct payment is not a grant under section 16B.97 and is not subject to statewide
18.12 grant-making policies and laws, including but not limited to sections 16A.15 and 16C.05,
18.13 except as specifically required by the commissioner. A direct payment must be used for the
18.14 purposes and allowable activities established by the commissioner and is subject to financial
18.15 oversight, reporting, and monitoring requirements under subdivision 11.

18.16 Sec. .... Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision
18.17 to read:

18.18 Subd. 3a. **Authority and rulemaking.** (a) The commissioner may distribute money
18.19 under this section through direct payments to counties or Tribes when the commissioner
18.20 determines that a direct payment is the most effective and efficient method to support the
18.21 delivery of adult mental health services, Tribal government activities, or county
18.22 responsibilities under this section. The commissioner shall establish eligibility criteria,
18.23 allowable uses, documentation standards, and reporting requirements for recipients of direct
18.24 payments. The commissioner is authorized to engage in rulemaking to fulfill the requirements
18.25 of this subdivision.

18.26 (b) By January 1, 2027, the commissioner must submit a report to the chairs and ranking
18.27 minority members of the legislative committees with jurisdiction over human services
18.28 finance and policy that includes, at a minimum, the commissioner's plan for determining
18.29 direct payment eligibility criteria, allowable uses of direct payments, documentation
18.30 standards, and reporting requirements for recipients of direct payments.

Sec. .... Minnesota Statutes 2025 Supplement, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Programs and eligible services ~~and programs~~.** (a) The following three distinct ~~grant~~ programs ~~are funded~~ may receive direct payments under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) ~~In addition,~~ The following services are eligible for ~~grant funds~~ funding as direct payments under this section as the payor of last resort:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services, including the purchase and renovation of vehicles by mobile crisis teams in order to provide protected transport under section 256B.0625, subdivision 17, paragraph (l), clause (6);

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management; and

(20) transportation.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. .... Minnesota Statutes 2024, section 245.4661, subdivision 10, is amended to read:

Subd. 10. **Commissioner duty to report on use of ~~grant~~ funds biennially.** (a) By November 1, 2016, and biennially thereafter, the commissioner ~~of human services~~ shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding to adult mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

(b) This subdivision expires January 1, 2032.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. .... Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision to read:

Subd. 12. **Oversight of direct payments.** (a) The commissioner shall develop and maintain monitoring, financial review, and accountability procedures for all direct payments issued under this section.

(b) Recipients of direct payments must comply with all documentation, reporting, and expenditure requirements established by the commissioner.

(c) The commissioner may require corrective action, suspend payments, or recover funds if a recipient fails to comply with requirements established under this subdivision.

(d) The commissioner shall develop a direct payment acknowledgment process to ensure that recipients understand the terms, conditions, and oversight requirements associated with direct payments.

21.1 (e) The commissioner is authorized to engage in rulemaking to fulfill the requirements
21.2 of this subdivision.

21.3 (f) By January 1, 2027, the commissioner must submit a report to the chairs ranking
21.4 minority members of the legislative committees with jurisdiction over human services
21.5 finance and policy that, at a minimum, describes the commissioner's development of the
21.6 monitoring, financial review, and accountability procedures as required under this section.

21.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

21.8 Sec. .... Minnesota Statutes 2024, section 254A.03, subdivision 2, is amended to read:

21.9 Subd. 2. **American Indian programs.** There is hereby created a section of American
21.10 Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human
21.11 Services, to be headed by a special assistant for American Indian programs on substance
21.12 misuse and substance use disorder and two assistants to that position. The section shall be
21.13 staffed with all personnel necessary to fully administer programming for substance misuse
21.14 and substance use disorder services for American Indians in the state. The special assistant
21.15 position shall be filled by a person with considerable practical experience in and
21.16 understanding of substance misuse and substance use disorder in the American Indian
21.17 community, who shall be responsible to the director of the Alcohol and Drug Abuse Section
21.18 created in subdivision 1 and shall be in the unclassified service. The special assistant shall
21.19 meet and consult with the American Indian Advisory Council as described in section
21.20 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report
21.21 on the status of substance misuse and substance use disorder among American Indians in
21.22 the state of Minnesota. The special assistant with the approval of the director shall:

21.23 (1) administer direct payments using funds appropriated for American Indian groups,
21.24 organizations and reservations within the state for American Indian substance misuse and
21.25 substance use disorder programs;

21.26 (2) establish policies and procedures for such American Indian programs with the
21.27 assistance of the American Indian Advisory Board; and

21.28 (3) hire and supervise staff to assist in the administration of the American Indian program
21.29 section within the Alcohol and Drug Abuse Section of the Department of Human Services.

21.30 **EFFECTIVE DATE.** This section is effective January 1, 2027.

Sec. .... Minnesota Statutes 2025 Supplement, section 254B.02, subdivision 5, is amended to read:

Subd. 5. **Tribal allocation.** The commissioner may make direct payments to Tribal Nation servicing agencies from money allocated under this section to support individuals with substance use disorders and determine eligibility for behavioral health fund payments. The payment must not be less than 133 percent of the Tribal Nations payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

EFFECTIVE DATE. This section is effective January 1, 2027."

Page 122, after line 20, insert:

"Sec. .... Minnesota Statutes 2025 Supplement, section 254B.0505, subdivision 8, is amended to read:

Subd. 8. **Peer recovery support services requirements.** Eligible vendors of peer recovery support services must~~:~~

~~(1)~~ submit to a review by the commissioner of up to ten percent of all medical assistance and behavioral health fund claims to determine the medical necessity of peer recovery support services for entities billing for peer recovery support services individually and not receiving a daily rate~~; and~~.

~~(2) limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services.~~

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. .... Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding a subdivision to read:

Subd. 9. **Billing limits.** (a) Treatment coordination must not exceed five hours per week per recipient.

(b) Peer recovery support services must not exceed ten hours per week per recipient. Services must be provided in person and may not include time spent transporting a recipient.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. .... Minnesota Statutes 2025 Supplement, section 254B.0509, subdivision 2, is amended to read:

Subd. 2. **Annual adjustments.** Effective January 1, 2027, and annually thereafter, the commissioner of human services must adjust the payment rates under ~~subdivision 1~~ section 254B.0505, subdivision 1, clauses (1) through (9), according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. Notwithstanding this subdivision, rates must not be adjusted lower than those established on January 1, 2026.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. .... Minnesota Statutes 2024, section 254B.17, is amended to read:

254B.17 WITHDRAWAL MANAGEMENT START-UP AND CAPACITY-BUILDING GRANTS.

The commissioner must establish start-up and capacity-building grants for prospective, ~~or~~ new, or existing substance use disorder treatment or withdrawal management programs ~~licensed under chapter 245F~~ that will meet ASAM criteria for medically ~~monitored~~ managed or clinically monitored levels of care by integrating withdrawal management services into outpatient, intensive outpatient, or residential treatment services. Grants must be used to measurably increase client capacity or expand available services, and must align services with ASAM criteria. Grants may be used to add medications for opioid use disorder to a grantee's available services, and for capacity-building expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring staff or contracting with medical services providers;

(2) costs associated with staff retention;

(3) the purchase of office equipment and supplies;

(4) the purchase of software;

(5) costs associated with obtaining applicable and required licenses;

(6) business formation costs;

(7) costs associated with staff training; ~~and~~

(8) the purchase of medical equipment and supplies necessary to meet health and safety requirements~~.~~;

24.1 (9) costs associated with adding or improving physical space;

24.2 (10) start-up costs associated with adding new locations; and

24.3 (11) costs associated with becoming ASAM certified for medically managed levels of
24.4 care.

24.5 Sec. .... Minnesota Statutes 2024, section 256B.04, subdivision 23, is amended to read:

24.6 Subd. 23. **Medical assistance costs for certain inmates.** (a) The commissioner shall
24.7 execute an interagency agreement with the commissioner of corrections to recover the state
24.8 cost attributable to medical assistance eligibility for inmates of public institutions admitted
24.9 to a medical institution on an inpatient basis. The annual amount to be transferred from the
24.10 Department of Corrections under the agreement must include all eligible state medical
24.11 assistance costs, including administrative costs incurred by the Department of Human
24.12 Services, attributable to inmates under state and county jurisdiction admitted to medical
24.13 institutions on an inpatient basis that are related to the implementation of section 256B.055,
24.14 subdivision 14, paragraph (c). This paragraph expires upon the effective date of paragraph
24.15 (b).

24.16 (b) Effective January 1, 2027, or upon federal approval, whichever is later, the
24.17 commissioner shall execute an interagency agreement with the commissioner of corrections
24.18 to recover the state cost attributable to medical assistance eligibility for inmates of public
24.19 institutions admitted to a medical institution on an inpatient basis. The annual amount to
24.20 be transferred from the Department of Corrections under the agreement must include all
24.21 eligible state medical assistance costs, including administrative costs incurred by the
24.22 Department of Human Services attributable to inmates under state and county jurisdiction
24.23 admitted to medical institutions on an inpatient basis that are related to implementation of
24.24 section 256B.0618, paragraph (b).

24.25 **EFFECTIVE DATE.** This section is effective the day following final enactment."

24.26 Page 123, lines 10 and 12, delete "2027" and insert "2028"

24.27 Page 124, line 8, before the semicolon, insert ", through direct coordination between
24.28 providers that includes timely communication, active engagement of the individual when
24.29 feasible, and facilitation of continuity of care upon release"

24.30 Page 126, after line 16, insert:

25.1 "Sec. .... Minnesota Statutes 2024, section 256B.0623, is amended by adding a subdivision
25.2 to read:

25.3 Subd. 15. **Billing limits.** Effective January 1, 2027, services under this section must not
25.4 exceed four hours per week per recipient, with a maximum of 18 hours per month. Prior
25.5 authorization is required for services exceeding 200 hours per year."

25.6 Page 126, line 19, delete "2027" and insert "2028"

25.7 Page 126, after line 21, insert:

25.8 "Sec. .... Minnesota Statutes 2024, section 256B.0671, is amended by adding a subdivision
25.9 to read:

25.10 Subd. 14. **Billing limits.** Child and family psychoeducation services under this section
25.11 must not exceed two hours per day, three days per week per recipient.

25.12 **EFFECTIVE DATE.** This section is effective January 1, 2027."

25.13 Page 126, line 23, before the stricken "Notwithstanding" insert "(a)" and reinstate the
25.14 stricken language

25.15 Page 126, line 27, after the period, insert "This paragraph expires upon the effective
25.16 date of paragraph (b)."

25.17 Page 126, after line 27, insert:

25.18 "(b) Effective January 1, 2027, or upon federal approval, whichever is later, individuals
25.19 are eligible to receive services under this demonstration if they are eligible under section
25.20 256B.055, subdivision 3a, 6, 7, 7a, 9, 15, 16, or 17, as determined by the commissioner in
25.21 collaboration with correctional facilities, local governments, and Tribal governments.

25.22 **EFFECTIVE DATE.** This section is effective the day following final enactment"

25.23 Page 126, before line 28, insert:

25.24 "Sec. .... Minnesota Statutes 2024, section 256B.0761, subdivision 3, is amended to read:

25.25 Subd. 3. **Eligible correctional facilities.** (a) The commissioner's waiver application is
25.26 limited to:

25.27 (1) three state correctional facilities to be determined by the commissioner of corrections,
25.28 one of which must be the Minnesota Correctional Facility-Shakopee;

26.1 ~~(2) two facilities for delinquent children and youth licensed under section 241.021,~~
26.2 ~~subdivision 2, identified in coordination with the Minnesota Juvenile Detention Association~~
26.3 ~~and the Minnesota Sheriffs' Association;~~

26.4 ~~(3)~~ (2) four correctional facilities for adults licensed under section 241.021, subdivision
26.5 1, identified in coordination with the Minnesota Sheriffs' Association and the Association
26.6 of Minnesota Counties; and

26.7 ~~(4)~~ (3) one correctional facility owned and managed by a Tribal government or a facility
26.8 located outside of the seven-county metropolitan area that has an inmate census with a
26.9 significant proportion of Tribal members or American Indians.

26.10 (b) Additional facilities may be added to the waiver contingent on legislative authorization
26.11 and appropriations.

26.12 Sec. .... Minnesota Statutes 2024, section 256B.0943, is amended by adding a subdivision
26.13 to read:

26.14 Subd. 14. **Billing limits.** (a) Skills training under this section must not exceed two hours
26.15 per day, three days per week per recipient. Prior authorization is required for services
26.16 exceeding 200 hours per year.

26.17 (b) Mental health behavioral aide services under this section must not exceed six hours
26.18 per day, three days per week per recipient. Prior authorization is required for services
26.19 exceeding 200 hours per year.

26.20 **EFFECTIVE DATE.** This section is effective January 1, 2027.

26.21 Sec. .... Minnesota Statutes 2025 Supplement, section 256I.04, subdivision 2a, is amended
26.22 to read:

26.23 Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph
26.24 (b), an agency may not enter into an agreement with an establishment to provide housing
26.25 support unless:

26.26 (1) the establishment is licensed by the Department of Health as a hotel and restaurant;
26.27 a board and lodging establishment; a boarding care home before March 1, 1985; or a
26.28 supervised living facility, and the service provider for residents of the facility is licensed
26.29 under chapter 245A. However, an establishment licensed by the Department of Health to
26.30 provide lodging need not also be licensed to provide board if meals are being supplied to
26.31 residents under a contract with a food vendor who is licensed by the Department of Health;

27.1 (2) the residence is: (i) licensed by the commissioner of human services under Minnesota
27.2 Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior
27.3 to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265;
27.4 (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120,
27.5 with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02,
27.6 subdivision 4a, as a community residential setting by the commissioner of human services;

27.7 (3) the facility is licensed under chapter 144G and provides three meals a day; or

27.8 (4) effective ~~January 1, 2027~~ July 1, 2026, the establishment is licensed by the Department
27.9 of Health as a board and lodging establishment and is certified by the commissioner as a
27.10 recovery residence in accordance with section 254B.215, subdivision 3, that is subject to
27.11 the requirements of section 256I.04, subdivisions 2a to 2f. The Department of Human
27.12 Services must serve as the lead agency for agreements entered into under this clause.

27.13 (b) The requirements under paragraph (a) do not apply to establishments exempt from
27.14 state licensure because they are:

27.15 (1) located on Indian reservations and subject to tribal health and safety requirements;
27.16 or

27.17 (2) supportive housing establishments where an individual has an approved habitability
27.18 inspection and an individual lease agreement.

27.19 (c) Supportive housing establishments that serve individuals who have experienced
27.20 long-term homelessness and emergency shelters must participate in the homeless management
27.21 information system and a coordinated assessment system as defined by the commissioner.

27.22 (d) Effective July 1, 2016, an agency shall not have an agreement with a provider of
27.23 housing support unless all staff members who have direct contact with recipients:

27.24 (1) have skills and knowledge acquired through one or more of the following:

27.25 (i) a course of study in a health- or human services-related field leading to a bachelor
27.26 of arts, bachelor of science, or associate's degree;

27.27 (ii) one year of experience with the target population served;

27.28 (iii) experience as a mental health certified peer specialist according to section 256B.0615;
27.29 or

27.30 (iv) meeting the requirements for unlicensed personnel under sections 144A.43 to
27.31 144A.483;

28.1 (2) hold a current driver's license appropriate to the vehicle driven if transporting
28.2 recipients;

28.3 (3) complete training on vulnerable adults mandated reporting and child maltreatment
28.4 mandated reporting, where applicable; and

28.5 (4) complete housing support orientation training offered by the commissioner.

28.6 Sec. .... Minnesota Statutes 2024, section 297E.02, subdivision 3, is amended to read:

28.7 Subd. 3. **Collection; disposition.** (a) Taxes imposed by this section are due and payable
28.8 to the commissioner when the gambling tax return is required to be filed. Distributors must
28.9 file their monthly sales figures with the commissioner on a form prescribed by the
28.10 commissioner. Returns covering the taxes imposed under this section must be filed with
28.11 the commissioner on or before the 20th day of the month following the close of the previous
28.12 calendar month. The commissioner shall prescribe the content, format, and manner of returns
28.13 or other documents pursuant to section 270C.30. The proceeds, along with the revenue
28.14 received from all license fees and other fees under sections 349.11 to 349.191, 349.211,
28.15 and 349.213, must be paid to the commissioner of management and budget for deposit in
28.16 the general fund.

28.17 (b) The sales tax imposed by chapter 297A on the sale of pull-tabs and tipboards by the
28.18 distributor is imposed on the retail sales price. The retail sale of pull-tabs or tipboards by
28.19 the organization is exempt from taxes imposed by chapter 297A and is exempt from all
28.20 local taxes and license fees except a fee authorized under section 349.16, subdivision 8.

28.21 (c) One-half of one percent of the revenue deposited in the general fund under paragraph
28.22 (a), is appropriated to the commissioner of human services for the compulsive gambling
28.23 treatment program established under section 245.98. One-half of one percent of the revenue
28.24 deposited in the general fund under paragraph (a), is appropriated to the commissioner of
28.25 human services for a grant to the state affiliate recognized by the National Council on
28.26 Problem Gambling to increase public awareness of problem gambling, education and training
28.27 for individuals and organizations providing effective treatment services to problem gamblers
28.28 and their families, and research relating to problem gambling. Money appropriated by this
28.29 paragraph must supplement and must not replace existing state funding for these programs.
28.30 The balance of amounts appropriated under this paragraph that are unencumbered and
28.31 unspent at the close of a fiscal year must be available in the next fiscal year for the same
28.32 purposes, and must not cancel to the fund from which the amounts were appropriated.

29.1 (d) The commissioner of human services must provide to the state affiliate recognized
29.2 by the National Council on Problem Gambling a monthly statement of the amounts deposited
29.3 under paragraph (c). Beginning January 1, 2022, the commissioner of human services must
29.4 provide to the chairs and ranking minority members of the legislative committees with
29.5 jurisdiction over treatment for problem gambling and to the state affiliate recognized by the
29.6 National Council on Problem Gambling an annual reconciliation of the amounts deposited
29.7 under paragraph (c). The annual reconciliation under this paragraph must include the amount
29.8 allocated to the commissioner of human services for the compulsive gambling treatment
29.9 program established under section 245.98, and the amount allocated to the state affiliate
29.10 recognized by the National Council on Problem Gambling. The annual reconciliation must
29.11 also include any rollover amounts from the previous fiscal year and the utilization of those
29.12 amounts during the current reporting period."

29.13 Page 128, delete section 16

29.14 Page 130, lines 8 and 12, delete "2027" and insert "2028"

29.15 Page 149, line 11, strike "256B.0624, subdivision 11" and insert "245I.24, subdivision
29.16 11"

29.17 Page 167, after line 9, insert:

29.18 "Sec. .... Minnesota Statutes 2024, section 245I.23, subdivision 4, is amended to read:

29.19 Subd. 4. **Required intensive residential treatment services.** (a) On a daily basis, the
29.20 license holder must follow a client's treatment plan to provide intensive residential treatment
29.21 services to the client to improve the client's functioning.

29.22 (b) The license holder must offer and have the capacity to directly provide the following
29.23 treatment services to each client:

29.24 (1) daily rehabilitative mental health services;

29.25 (2) crisis prevention planning to assist a client with:

29.26 (i) identifying and addressing patterns in the client's history and experience of the client's
29.27 mental illness; and

29.28 (ii) developing crisis prevention strategies that include de-escalation strategies that have
29.29 been effective for the client in the past;

29.30 (3) health services and administering medication;

29.31 (4) co-occurring substance use disorder treatment;

30.1 (5) engaging the client's family and other natural supports in the client's treatment and
30.2 educating the client's family and other natural supports to strengthen the client's social and
30.3 family relationships; and

30.4 (6) making referrals for the client to other service providers in the community and
30.5 supporting the client's transition from intensive residential treatment services to another
30.6 setting.

30.7 (c) The license holder must include Illness Management and Recovery (IMR), Enhanced
30.8 Illness Management and Recovery (E-IMR), or other similar interventions in the license
30.9 holder's programming as approved by the commissioner.

30.10 Sec. .... Minnesota Statutes 2024, section 245I.23, subdivision 5, is amended to read:

30.11 Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the
30.12 license holder must follow a client's individual crisis treatment plan to provide services to
30.13 the client in residential crisis stabilization to improve the client's functioning.

30.14 (b) The license holder must offer and have the capacity to directly provide the following
30.15 treatment services to the client:

30.16 (1) daily crisis stabilization services as described in section 256B.0624, subdivision 7;

30.17 (2) rehabilitative mental health services;

30.18 (3) health services and administering the client's medications; and

30.19 (4) making referrals for the client to other service providers in the community and
30.20 supporting the client's transition from residential crisis stabilization to another setting.

30.21 Sec. .... Minnesota Statutes 2025 Supplement, section 245I.23, subdivision 7, is amended
30.22 to read:

30.23 Subd. 7. **Intensive residential treatment services assessment and treatment**
30.24 **planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and
30.25 document the client's immediate needs, including the client's:

30.26 (1) health and safety, including the client's need for crisis assistance;

30.27 (2) responsibilities for children, family and other natural supports, and employers; and

30.28 (3) housing and legal issues.

30.29 (b) Within 24 hours of the client's admission, the license holder must complete an initial
30.30 treatment plan for the client. The license holder must:

31.1 (1) base the client's initial treatment plan on the client's referral information and an
31.2 assessment of the client's immediate needs;

31.3 (2) consider crisis assistance strategies that have been effective for the client in the past;

31.4 (3) identify the client's initial treatment goals, measurable treatment objectives, and
31.5 specific interventions, and the frequency of interventions, that the license holder will use
31.6 to help the client engage in treatment;

31.7 (4) identify the participants involved in the client's treatment planning. The client must
31.8 be a participant; and

31.9 (5) ensure that a treatment supervisor approves of the client's initial treatment plan if a
31.10 behavioral health practitioner or clinical trainee completes the client's treatment plan,
31.11 notwithstanding section 245I.08, subdivision 3.

31.12 (c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must
31.13 complete an individual abuse prevention plan as part of a client's initial treatment plan.

31.14 (d) Within five days of the client's admission and again within 60 days after the client's
31.15 admission, the license holder must complete a level of care assessment of the client. If the
31.16 license holder determines that a client does not need a medically monitored level of service,
31.17 a treatment supervisor must document how the client's admission to and continued services
31.18 in intensive residential treatment services are medically necessary for the client.

31.19 (e) Within ten days of a client's admission, the license holder must complete or review
31.20 and update the client's standard diagnostic assessment.

31.21 (f) Within ten days of a client's admission, the license holder must complete the client's
31.22 individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days
31.23 after the client's admission and again within 70 days after the client's admission, the license
31.24 holder must update the client's individual treatment plan. The license holder must focus the
31.25 client's treatment planning on preparing the client for a successful transition from intensive
31.26 residential treatment services to another setting. The individual treatment plan must be based
31.27 on the client's diagnostic assessment and functional assessment and must contain, at a
31.28 minimum, identified goals according to subdivision 4, paragraph (b), clauses (1) to (3), or
31.29 subdivision 5, paragraph (b), clause (1), as applicable. In addition to the required elements
31.30 of an individual treatment plan under section 245I.10, subdivision 8, the license holder must
31.31 identify the following information in the client's individual treatment plan: (1) the client's
31.32 referrals and resources for the client's health and safety; and (2) the staff persons who are
31.33 responsible for following up with the client's referrals and resources. If the client does not

32.1 receive a referral or resource that the client needs, the license holder must document the
32.2 reason that the license holder did not make the referral or did not connect the client to a
32.3 particular resource. The license holder is responsible for determining whether additional
32.4 follow-up is required on behalf of the client.

32.5 (g) Within 30 days of the client's admission, the license holder must complete a functional
32.6 assessment of the client. Within 60 days after the client's admission, the license holder must
32.7 update the client's functional assessment to include any changes in the client's functioning
32.8 and symptoms.

32.9 (h) For a client with a current substance use disorder diagnosis and for a client whose
32.10 substance use disorder screening in the client's standard diagnostic assessment indicates the
32.11 possibility that the client has a substance use disorder, the license holder must complete a
32.12 written assessment of the client's substance use within 30 days of the client's admission. In
32.13 the substance use assessment, the license holder must: (1) evaluate the client's history of
32.14 substance use, relapses, and hospitalizations related to substance use; (2) assess the effects
32.15 of the client's substance use on the client's relationships including with family member and
32.16 others; (3) identify financial problems, health issues, housing instability, and unemployment;
32.17 (4) assess the client's legal problems, past and pending incarceration, violence, and
32.18 victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking
32.19 prescribed medications, and noncompliance with psychosocial treatment.

32.20 (i) On a weekly basis, a mental health professional or certified rehabilitation specialist
32.21 must review each client's treatment plan and individual abuse prevention plan. The license
32.22 holder must document in the client's file each weekly review of the client's treatment plan
32.23 and individual abuse prevention plan. An individual treatment plan must be updated based
32.24 on new information gathered about the client's conditions, the client's level of participation,
32.25 and whether identified interventions have had the intended effect.

32.26 Sec. .... Minnesota Statutes 2025 Supplement, section 245I.23, subdivision 10, is amended
32.27 to read:

32.28 Subd. 10. **Minimum treatment team staffing levels and ratios.** (a) The license holder
32.29 must maintain a treatment team staffing level sufficient to:

32.30 (1) provide continuous daily coverage of all shifts;

32.31 (2) follow each client's treatment plan and meet each client's needs as identified in the
32.32 client's treatment plan;

32.33 (3) implement program requirements; and

33.1 (4) safely monitor and guide the activities of each client, taking into account the client's
33.2 level of behavioral and psychiatric stability, cultural needs, and vulnerabilities.

33.3 (b) The license holder must ensure that treatment team members:

33.4 (1) remain awake during all work hours; and

33.5 (2) are available to monitor and guide the activities of each client whenever clients are
33.6 present in the program.

33.7 (c) On each shift, the license holder must maintain a treatment team staffing ratio of at
33.8 least one treatment team member to nine clients. If the license holder is serving nine or
33.9 fewer clients, at least one treatment team member on the day shift must be a mental health
33.10 professional, clinical trainee, certified rehabilitation specialist, or behavioral health
33.11 practitioner. If the license holder is serving more than nine clients, at least one of the
33.12 treatment team members working during both the day and evening shifts must be a mental
33.13 health professional, clinical trainee, certified rehabilitation specialist, or behavioral health
33.14 practitioner.

33.15 (d) If the license holder provides residential crisis stabilization to clients and is serving
33.16 at least one client in residential crisis stabilization and more than four clients in residential
33.17 crisis stabilization and intensive residential treatment services, the license holder must
33.18 maintain a treatment team staffing ratio on each shift of at least two treatment team members
33.19 during the client's first 48 hours in residential crisis stabilization.

33.20 (e) The license holder must maintain documentation of a daily staffing schedule indicating
33.21 the names and credentials of individuals providing services, according to the record retention
33.22 requirements under section 245A.041.

33.23 Sec. .... Minnesota Statutes 2024, section 245I.23, subdivision 12, is amended to read:

33.24 Subd. 12. **Daily documentation.** (a) For each day that a client is present in the program,
33.25 the license holder must provide a daily summary in the client's file that includes observations
33.26 about the client's behavior and symptoms, including any critical incidents in which the client
33.27 was involved, and documentation of a daily medically necessary rehabilitation service
33.28 according to section 245I.08.

33.29 (b) For each day that a client is not present in the program, the license holder must
33.30 document the reason for a client's absence in the client's file.

Sec. .... Minnesota Statutes 2024, section 245I.23, subdivision 17, is amended to read:

Subd. 17. **Admissions referrals and determinations.** (a) The license holder must identify the information that the license holder needs to make a determination about a person's admission referral.

(b) The license holder must:

(1) always be available to receive referral information about a person seeking admission to the license holder's program;

(2) respond to the referral source within eight hours of receiving a referral and, within eight hours, communicate with the referral source about what information the license holder needs to make a determination concerning the person's admission;

(3) consider the license holder's staffing ratio and the areas of treatment team members' competency when determining whether the license holder is able to meet the needs of a person seeking admission; ~~and~~

(4) determine whether to admit a person within 72 hours of receiving all necessary information from the referral source~~.~~; and

(5) document client eligibility according to subdivision 15, paragraph (a), and subdivision 16."

Page 191, after line 23, insert:

"ARTICLE 6
UNIFORM SERVICE STANDARDS CONFORMING CHANGES

Section 1. Minnesota Statutes 2024, section 13.46, subdivision 7, is amended to read:

Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals and shall not be disclosed, except:

(1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;

(2) pursuant to court order;

(3) pursuant to a statute specifically authorizing access to or disclosure of mental health data or as otherwise provided by this subdivision;

35.1 (4) to personnel of the welfare system working in the same program or providing services
35.2 to the same individual or family to the extent necessary to coordinate services, provided
35.3 that a health record may be disclosed only as provided under section 144.293;

35.4 (5) to a health care provider governed by sections 144.291 to 144.298, to the extent
35.5 necessary to coordinate services; or

35.6 (6) with the consent of the client or patient.

35.7 (b) An agency of the welfare system may not require an individual to consent to the
35.8 release of mental health data as a condition for receiving services or for reimbursing a
35.9 community mental health center, mental health division of a county, or provider under
35.10 contract to deliver mental health services.

35.11 (c) Notwithstanding any other law to the contrary, a community mental health center,
35.12 mental health division of a county, or a mental health provider must disclose mental health
35.13 data to a law enforcement agency if the law enforcement agency provides the name of a
35.14 client or patient and communicates that the:

35.15 (1) client or patient is currently involved in a mental health crisis as defined in section
35.16 ~~256B.0624, subdivision 2, paragraph (j)~~ 245I.24, subdivision 2, paragraph (g), to which the
35.17 law enforcement agency has responded; and

35.18 (2) data is necessary to protect the health or safety of the client or patient or of another
35.19 person.

35.20 The scope of disclosure under this paragraph is limited to the minimum necessary for
35.21 law enforcement to safely respond to the mental health crisis. Disclosure under this paragraph
35.22 may include the name and telephone number of the psychiatrist, psychologist, therapist,
35.23 mental health professional, practitioner, or case manager of the client or patient, if known;
35.24 and strategies to address the mental health crisis. A law enforcement agency that obtains
35.25 mental health data under this paragraph shall maintain a record of the requestor, the provider
35.26 of the data, and the client or patient name. Mental health data obtained by a law enforcement
35.27 agency under this paragraph are private data on individuals and must not be used by the
35.28 law enforcement agency for any other purpose. A law enforcement agency that obtains
35.29 mental health data under this paragraph shall inform the subject of the data that mental
35.30 health data was obtained.

35.31 (d) In the event of a request under paragraph (a), clause (6), a community mental health
35.32 center, county mental health division, or provider must release mental health data to Criminal

36.1 Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal
36.2 Mental Health Court personnel communicate that the:

36.3 (1) client or patient is a defendant in a criminal case pending in the district court;

36.4 (2) data being requested is limited to information that is necessary to assess whether the
36.5 defendant is eligible for participation in the Criminal Mental Health Court; and

36.6 (3) client or patient has consented to the release of the mental health data and a copy of
36.7 the consent will be provided to the community mental health center, county mental health
36.8 division, or provider within 72 hours of the release of the data.

36.9 For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty
36.10 criminal calendar of the Hennepin County District Court for defendants with mental illness
36.11 and brain injury where a primary goal of the calendar is to assess the treatment needs of the
36.12 defendants and to incorporate those treatment needs into voluntary case disposition plans.
36.13 The data released pursuant to this paragraph may be used for the sole purpose of determining
36.14 whether the person is eligible for participation in mental health court. This paragraph does
36.15 not in any way limit or otherwise extend the rights of the court to obtain the release of mental
36.16 health data pursuant to court order or any other means allowed by law.

36.17 Sec. 2. Minnesota Statutes 2024, section 144.294, subdivision 2, is amended to read:

36.18 Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293,
36.19 subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental
36.20 health to a law enforcement agency if the law enforcement agency provides the name of
36.21 the patient and communicates that the:

36.22 (1) patient is currently involved in a mental health crisis as defined in section ~~256B.0624,~~
36.23 ~~subdivision 2, paragraph (j)~~ 245I.24, subdivision 2, paragraph (g), to which the law
36.24 enforcement agency has responded; and

36.25 (2) disclosure of the records is necessary to protect the health or safety of the patient or
36.26 of another person.

36.27 The scope of disclosure under this subdivision is limited to the minimum necessary for
36.28 law enforcement to safely respond to the mental health crisis. The disclosure may include
36.29 the name and telephone number of the psychiatrist, psychologist, therapist, mental health
36.30 professional, practitioner, or case manager of the patient, if known; and strategies to address
36.31 the mental health crisis. A law enforcement agency that obtains health records under this
36.32 subdivision shall maintain a record of the requestor, the provider of the information, and
36.33 the patient's name. Health records obtained by a law enforcement agency under this

subdivision are private data on individuals as defined in section 13.02, subdivision 12, and must not be used by law enforcement for any other purpose. A law enforcement agency that obtains health records under this subdivision shall inform the patient that health records were obtained.

Sec. 3. Minnesota Statutes 2025 Supplement, section 245.4835, subdivision 2, is amended to read:

Subd. 2. **Failure to maintain expenditures.** (a) If a county does not comply with subdivision 1, the commissioner shall require the county to develop a corrective action plan according to a format and timeline established by the commissioner. If the commissioner determines that a county has not developed an acceptable corrective action plan within the required timeline, or that the county is not in compliance with an approved corrective action plan, the protections provided to that county under section 245.485 do not apply.

(b) The commissioner shall consider the following factors to determine whether to approve a county's corrective action plan:

(1) the degree to which a county is maximizing revenues for mental health services from noncounty sources;

(2) the degree to which a county is expanding use of alternative services that meet mental health needs, but do not count as mental health services within existing reporting systems. If approved by the commissioner, the alternative services must be included in the county's base as well as subsequent years. The commissioner's approval for alternative services must be based on the following criteria:

(i) the service must be provided to children or adults with mental illness;

(ii) the services must be based on an individual treatment plan or individual community support plan as defined in the Comprehensive Mental Health Act; and

(iii) the services must be supervised by a mental health professional and provided by staff who meet the staff qualifications defined in sections ~~256B.0943, subdivision 7~~ 245I.30, subdivision 4, and ~~256B.0623, subdivision 5~~ 245I.22, subdivision 5.

(c) Additional county expenditures to make up for the prior year's underspending may be spread out over a two-year period.

38.1 Sec. 4. Minnesota Statutes 2025 Supplement, section 245.4871, subdivision 4, is amended
38.2 to read:

38.3 Subd. 4. **Case management service provider.** (a) "Case management service provider"
38.4 means a case manager or case manager associate employed by the county or other entity
38.5 authorized by the county board to provide case management services specified in subdivision
38.6 3 for the child with serious mental illness and the child's family.

38.7 (b) A case manager must:

38.8 (1) have experience and training in working with children;

38.9 (2) be a mental health practitioner under section 245I.04, subdivision 4, or have at least
38.10 a bachelor's degree in one of the behavioral sciences or a related field including, but not
38.11 limited to, social work, psychology, or nursing from an accredited college or university or
38.12 meet the requirements of paragraph (d);

38.13 (3) have experience and training in identifying and assessing a wide range of children's
38.14 needs;

38.15 (4) be knowledgeable about local community resources and how to use those resources
38.16 for the benefit of children and their families; and

38.17 (5) meet the supervision and continuing education requirements of paragraphs (e), (f),
38.18 and (g), as applicable.

38.19 (c) A case manager may be a member of any professional discipline that is part of the
38.20 local system of care for children established by the county board.

38.21 (d) A case manager who is not a mental health practitioner and does not have a bachelor's
38.22 degree or who has a bachelor's degree that is not in one of the behavioral sciences or related
38.23 fields must meet one of the requirements in clauses (1) to (5):

38.24 (1) have three or four years of experience as a case manager associate;

38.25 (2) be a registered nurse without a bachelor's degree who has a combination of specialized
38.26 training in psychiatry and work experience consisting of community interaction and
38.27 involvement or community discharge planning in a mental health setting totaling three years;

38.28 (3) be a person who qualified as a case manager under the 1998 Department of Human
38.29 Services waiver provision and meets the continuing education, supervision, and mentoring
38.30 requirements in this section;

39.1 (4) prior to direct service delivery, complete at least 80 hours of specific training on the
39.2 characteristics and needs of children with serious mental illness that is consistent with
39.3 national practices standards; or

39.4 (5) prior to direct service delivery, demonstrate competency in practice and knowledge
39.5 of the characteristics and needs of children with serious mental illness, consistent with
39.6 national practices standards.

39.7 (e) A case manager with at least 2,000 hours of supervised experience in the delivery
39.8 of mental health services to children must receive regular ongoing supervision and clinical
39.9 supervision totaling 38 hours per year, of which at least one hour per month must be clinical
39.10 supervision regarding individual service delivery with a case management supervisor. The
39.11 other 26 hours of supervision may be provided by a case manager with two years of
39.12 experience. Group supervision may not constitute more than one-half of the required
39.13 supervision hours.

39.14 (f) A case manager without 2,000 hours of supervised experience in the delivery of
39.15 mental health services to children with mental illness must:

39.16 (1) begin 40 hours of training approved by the commissioner of human services in case
39.17 management skills and in the characteristics and needs of children with serious mental
39.18 illness before beginning to provide case management services; and

39.19 (2) receive clinical supervision regarding individual service delivery from a mental
39.20 health professional at least one hour each week until the requirement of 2,000 hours of
39.21 experience is met.

39.22 (g) A case manager who is not licensed, registered, or certified by a health-related
39.23 licensing board must receive 30 hours of continuing education and training in serious mental
39.24 illness and mental health services every two years.

39.25 (h) Clinical supervision must be documented in the child's record. When the case manager
39.26 is not a mental health professional, the county board must provide or contract for needed
39.27 clinical supervision.

39.28 (i) The county board must ensure that the case manager has the freedom to access and
39.29 coordinate the services within the local system of care that are needed by the child.

39.30 (j) A case manager associate (CMA) must:

39.31 (1) work under the direction of a case manager or case management supervisor;

39.32 (2) be at least 21 years of age;

40.1 (3) have at least a high school diploma or its equivalent; and

40.2 (4) meet one of the following criteria:

40.3 (i) have an associate of arts degree in one of the behavioral sciences or human services;

40.4 (ii) be a registered nurse without a bachelor's degree;

40.5 (iii) have three years of life experience as a primary caregiver to a child with serious
40.6 mental illness as defined in subdivision 6 within the previous ten years;

40.7 (iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

40.8 (v) have 6,000 hours of supervised work experience in the delivery of mental health
40.9 services to children with mental illness; hours worked as a mental health behavioral aide I
40.10 or II under section ~~256B.0943, subdivision 7~~ 245I.30, subdivision 4,, may count toward the
40.11 6,000 hours of supervised work experience.

40.12 Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager
40.13 after four years of supervised work experience as a case manager associate. Individuals
40.14 meeting the criteria in item (v) may qualify as a case manager after three years of supervised
40.15 experience as a case manager associate.

40.16 (k) Case manager associates must meet the following supervision, mentoring, and
40.17 continuing education requirements:

40.18 (1) have 40 hours of preservice training described under paragraph (f), clause (1);

40.19 (2) receive at least 40 hours of continuing education in serious mental illness and mental
40.20 health service annually; and

40.21 (3) receive at least five hours of mentoring per week from a case management mentor.
40.22 A "case management mentor" means a qualified, practicing case manager or case management
40.23 supervisor who teaches or advises and provides intensive training and clinical supervision
40.24 to one or more case manager associates. Mentoring may occur while providing direct services
40.25 to consumers in the office or in the field and may be provided to individuals or groups of
40.26 case manager associates. At least two mentoring hours per week must be individual and
40.27 face-to-face.

40.28 (l) A case management supervisor must meet the criteria for a mental health professional
40.29 as specified in subdivision 27.

40.30 (m) An immigrant who does not have the qualifications specified in this subdivision
40.31 may provide case management services to child immigrants with serious mental illness of
40.32 the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Sec. 5. Minnesota Statutes 2024, section 245.4882, subdivision 6, is amended to read:

Subd. 6. **Crisis admissions and stabilization.** (a) A child may be referred for residential treatment services under this section for the purpose of crisis stabilization by:

(1) a mental health professional as defined in section 245I.04, subdivision 2;

(2) a physician licensed under chapter 147 who is assessing a child in an emergency department; or

(3) a member of a mobile crisis team who meets the qualifications under section ~~256B.0624, subdivision 5~~ 245I.24, subdivision 5.

(b) A provider making a referral under paragraph (a) must conduct an assessment of the child's mental health needs and make a determination that the child is experiencing a mental health crisis and is in need of residential treatment services under this section.

(c) A child may receive services under this subdivision for up to 30 days and must be subject to the screening and admissions criteria and processes under section 245.4885 thereafter.

Sec. 6. Minnesota Statutes 2025 Supplement, section 245.735, subdivision 4d, is amended to read:

Subd. 4d. **Requirements for integrated treatment plans.** (a) An integrated treatment plan must be completed within 60 calendar days following the preliminary screening and risk assessment and updated no less frequently than every six months or when the client's circumstances change.

(b) Only a mental health professional may complete an integrated treatment plan. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate. An alcohol and drug counselor may approve the integrated treatment plan. The integrated treatment plan must be developed

through a shared decision-making process with the client, the client's support system if the client chooses, or, for children, with the family or caregivers.

(c) The integrated treatment plan must:

(1) use the ASAM 6 dimensional framework; and

(2) incorporate prevention, medical and behavioral health needs, and service delivery.

(d) The psychiatric evaluation and management service fulfills requirements for the integrated treatment plan when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC must complete an integrated treatment plan within 60 calendar days of a client's referral for additional CCBHC services.

(e) Notwithstanding any law to the contrary, an integrated treatment plan developed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 245G.06, subdivision 1;

(2) section 245G.09, subdivision 3, paragraph (a), clause (6); and

(3) section 245I.10, subdivisions 7 and 8~~; and~~.

~~(4) section 256B.0943, subdivision 6, paragraph (b), clause (2).~~

Sec. 7. Minnesota Statutes 2024, section 245A.26, subdivision 3, is amended to read:

Subd. 3. **Eligibility for services.** An individual is eligible for children's residential crisis stabilization services if the individual is under 21 years of age and meets the eligibility criteria for crisis services under section ~~256B.0624, subdivision 3~~ 245I.24, subdivision 3.

Sec. 8. Minnesota Statutes 2024, section 245A.26, subdivision 4, is amended to read:

Subd. 4. **Required services; providers.** (a) A license holder providing residential crisis stabilization services must continually follow a client's individual crisis treatment plan to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to a client:

(1) crisis stabilization services as described in section ~~256B.0624, subdivision 7~~ 245I.24, subdivision 9;

(2) mental health services as specified in the client's individual crisis treatment plan, according to the client's treatment needs;

(3) health services and medication administration, if applicable; and

(4) referrals for the client to community-based treatment providers and support services for the client's transition from residential crisis stabilization to another treatment setting.

(c) Children's residential crisis stabilization services must be provided by a qualified staff person listed in section ~~256B.0624, subdivision 8~~ 245I.24, subdivision 9, paragraph (b), according to the scope of practice for the individual staff person's position.

Sec. 9. Minnesota Statutes 2024, section 245A.26, subdivision 5, is amended to read:

Subd. 5. **Assessment and treatment planning.** (a) Within 12 hours of a client's admission for residential crisis stabilization, the license holder must assess the client and document the client's immediate needs, including the client's:

(1) health and safety, including the need for crisis assistance;

(2) need for connection to family and other natural supports;

(3) if applicable, housing and legal issues; and

(4) if applicable, responsibilities for children, family, and other natural supports, and employers.

(b) Within 24 hours of a client's admission for residential crisis stabilization, the license holder must complete a crisis treatment plan for the client, according to the requirements for a crisis treatment plan under section ~~256B.0624, subdivision 11~~ 245I.24, subdivision 11. The license holder must base the client's crisis treatment plan on the client's referral information and the assessment of the client's immediate needs under paragraph (a). A mental health professional or a clinical trainee under the supervision of a mental health professional must complete the crisis treatment plan. A crisis treatment plan completed by a clinical trainee must contain documentation of approval, as defined in section 245I.02, subdivision 2, by a mental health professional within five business days of initial completion by the clinical trainee.

(c) A mental health professional must review a client's crisis treatment plan each week and document the weekly reviews in the client's client file.

(d) For a client receiving children's residential crisis stabilization services who is 18 years of age or older, the license holder must complete an individual abuse prevention plan for the client, pursuant to section 245A.65, subdivision 2, as part of the client's crisis treatment plan.

Sec. 10. Minnesota Statutes 2024, section 245C.10, subdivision 8, is amended to read:

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section ~~256B.0943~~ <u>245I.30</u>, through a fee of no more than $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 11. Minnesota Statutes 2024, section 245I.23, subdivision 5, is amended to read:

Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the license holder must follow a client's individual crisis treatment plan to provide services to the client in residential crisis stabilization to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to the client:

(1) crisis stabilization services as described in section ~~256B.0624, subdivision 7~~ <u>245I.24, subdivision 9</u>;

(2) rehabilitative mental health services;

(3) health services and administering the client's medications; and

(4) making referrals for the client to other service providers in the community and supporting the client's transition from residential crisis stabilization to another setting.

Sec. 12. Minnesota Statutes 2024, section 245I.23, subdivision 8, is amended to read:

Subd. 8. **Residential crisis stabilization assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate the client and document the client's immediate needs, including the client's:

(1) health and safety, including the client's need for crisis assistance;

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of a client's admission, the license holder must complete a crisis treatment plan for the client under section ~~256B.0624, subdivision 11~~ <u>245I.24, subdivision 11</u>. The license holder must base the client's crisis treatment plan on the client's referral information and an assessment of the client's immediate needs.

45.1 (c) Section 245A.65, subdivision 2, paragraph (b), requires the license holder to complete
45.2 an individual abuse prevention plan for a client as part of the client's crisis treatment plan.

45.3 Sec. 13. Minnesota Statutes 2024, section 245I.23, subdivision 16, is amended to read:

45.4 Subd. 16. **Residential crisis stabilization services admission criteria.** An eligible client
45.5 for residential crisis stabilization is an individual who is age 18 or older and meets the
45.6 eligibility criteria in section ~~256B.0624, subdivision 3~~ <u>245I.24, subdivision 3</u>.

45.7 Sec. 14. Minnesota Statutes 2024, section 256B.092, subdivision 14, is amended to read:

45.8 Subd. 14. **Reduce avoidable behavioral crisis emergency room admissions,**
45.9 **psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons
45.10 receiving home and community-based services authorized under this section who have had
45.11 two or more admissions within a calendar year to an emergency room, psychiatric unit, or
45.12 institution must receive consultation from a mental health professional as defined in section
45.13 245.462, subdivision 18, or a behavioral professional as defined in the home and
45.14 community-based services state plan within 30 days of discharge. The mental health
45.15 professional or behavioral professional must:

45.16 (1) conduct a functional assessment of the crisis incident as defined in section 245D.02,
45.17 subdivision 11, which led to the hospitalization with the goal of developing proactive
45.18 strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable
45.19 hospitalizations due to a behavioral crisis;

45.20 (2) use the results of the functional assessment to amend the support plan set forth in
45.21 section 245D.02, subdivision 4b, to address the potential need for additional staff training,
45.22 increased staffing, access to crisis mobility services, mental health services, use of
45.23 technology, and crisis stabilization services in section ~~256B.0624, subdivision 7~~ <u>245I.24,</u>
45.24 <u>subdivision 9</u>; and

45.25 (3) identify the need for additional consultation, testing, and mental health crisis
45.26 intervention team services as defined in section 245D.02, subdivision 20, psychotropic
45.27 medication use and monitoring under section 245D.051, and the frequency and duration of
45.28 ongoing consultation.

45.29 (b) For the purposes of this subdivision, "institution" includes, but is not limited to, the
45.30 Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

Sec. 15. Minnesota Statutes 2024, section 256B.49, subdivision 25, is amended to read:

Subd. 25. **Reduce avoidable behavioral crisis emergency room admissions, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section 245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

(1) conduct a functional assessment of the crisis incident as defined in section 245D.02, subdivision 11, which led to the hospitalization with the goal of developing proactive strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable hospitalizations due to a behavioral crisis;

(2) use the results of the functional assessment to amend the support plan in section 245D.02, subdivision 4b, to address the potential need for additional staff training, increased staffing, access to crisis mobility services, mental health services, use of technology, and crisis stabilization services in section ~~256B.0624, subdivision 7~~ 245I.24, subdivision 9; and

(3) identify the need for additional consultation, testing, mental health crisis intervention team services as defined in section 245D.02, subdivision 20, psychotropic medication use and monitoring under section 245D.051, and the frequency and duration of ongoing consultation.

(b) For the purposes of this subdivision, "institution" includes, but is not limited to, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

Sec. 16. Minnesota Statutes 2025 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

47.1 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements
47.2 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,
47.3 title 42, sections 600.510 and 600.520.

47.4 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic
47.5 disease must comply with the requirements of section 62Q.481.

47.6 (e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic
47.7 services or testing that a health care provider determines an enrollee requires after a
47.8 mammogram, as specified under section 62A.30, subdivision 5.

47.9 (f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to
47.10 tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

47.11 (g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis
47.12 (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or
47.13 treatment of the human immunodeficiency virus (HIV).

47.14 (h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention
47.15 or crisis assessment as defined in section ~~256B.0624, subdivision 2~~ <u>245I.24, subdivision</u>
47.16 <u>2</u>."

47.17 Page 191, after line 25, insert:

47.18 "Sec. .... Minnesota Statutes 2025 Supplement, section 144.0724, subdivision 11, is
47.19 amended to read:

47.20 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment
47.21 of long-term care services, a recipient must be determined, using assessments defined in
47.22 subdivision 4, to meet one of the following nursing facility level of care criteria:

47.23 (1) the person requires formal clinical monitoring at least once per day;

47.24 (2) the person needs the assistance of another person or constant supervision to begin
47.25 and complete at least four of the following activities of living: bathing, bed mobility, dressing,
47.26 eating, grooming, toileting, transferring, and walking;

47.27 (3) the person needs the assistance of another person or constant supervision to begin
47.28 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

47.29 (4) the person has significant difficulty with memory, using information, daily decision
47.30 making, or behavioral needs that require intervention;

47.31 (5) the person has had a qualifying nursing facility stay of at least 90 days;

48.1 (6) the person meets the nursing facility level of care criteria determined 90 days after
48.2 admission or on the first quarterly assessment after admission, whichever is later; or

48.3 (7) the person is determined to be at risk for nursing facility admission or readmission
48.4 ~~through a face-to-face long-term care consultation assessment as specified in section~~
48.5 ~~256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, Tribe, or managed care~~
48.6 ~~organization under contract with the Department of Human Services~~. The person is
48.7 considered at risk under this clause if the person currently lives alone or will live alone or
48.8 be homeless without the person's current housing and also meets one of the following criteria:

48.9 (i) the person has experienced a fall resulting in a fracture;

48.10 (ii) the person has been determined to be at risk of maltreatment or neglect, including
48.11 self-neglect; or

48.12 (iii) the person has a sensory impairment that substantially impacts functional ability
48.13 and maintenance of a community residence.

48.14 (b) The assessment used to establish medical assistance payment for nursing facility
48.15 services must be the most recent assessment performed under subdivision 4, paragraph (b),
48.16 that occurred no more than 90 calendar days before the effective date of medical assistance
48.17 eligibility for payment of long-term care services. In no case shall medical assistance payment
48.18 for long-term care services occur prior to the date of the determination of nursing facility
48.19 level of care.

48.20 (c) The assessment used to establish medical assistance payment for long-term care
48.21 services provided under chapter 256S and section 256B.49 and alternative care payment
48.22 for services provided under section 256B.0913 must be the most recent face-to-face
48.23 assessment performed under section 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28,
48.24 that occurred no more than one calendar year before the effective date of medical assistance
48.25 eligibility for payment of long-term care services.

48.26 <u>**EFFECTIVE DATE.** This section is effective January 1, 2027.</u>"

48.27 Page 193, after line 5, insert:

48.28 "Sec. .... Minnesota Statutes 2024, section 256.975, subdivision 7b, is amended to read:

48.29 Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal
48.30 screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

48.31 (1) a person who, having entered an acute care facility from a certified nursing facility,
48.32 is returning to a certified nursing facility; or

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the Veterans Administration; and

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility~~; and~~.

~~(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act.~~

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during Senior LinkAge Line nonworking hours;

(2) a physician, advanced practice registered nurse, or physician assistant has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician, advanced practice registered nurse, or physician assistant has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the Senior LinkAge Line is contacted on the first working day following the emergency admission.

(e) Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following

50.1 situations: hospital admission for observation, care in an emergency room without hospital
50.2 admission, or following hospital 24-hour bed care and from whom admission is being sought
50.3 on a nonworking day.

50.4 (f) A nursing facility must provide written information to all persons admitted regarding
50.5 the person's right to request and receive long-term care consultation services as defined in
50.6 section 256B.0911, subdivision 11. The information must be provided prior to the person's
50.7 discharge from the facility and in a format specified by the commissioner.

50.8 **EFFECTIVE DATE.** This section is effective January 1, 2027."

50.9 Page 193, delete section 2

50.10 Page 211, line 10, delete "development" and insert "developmental"

50.11 Page 213, delete lines 7 and 8

50.12 Renumber the clauses in sequence

50.13 Page 213, line 15, delete "overnight" and insert "night"

50.14 Page 214, after line 15, insert:

50.15 "Sec. .... Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 8, is
50.16 amended to read:

50.17 Subd. 8. **Unit-based services with programming; component values and calculation**
50.18 **of payment rates.** (a) For the purpose of this section, unit-based services with programming
50.19 include employment exploration services, employment development services, employment
50.20 support services, individualized home supports with family training, individualized home
50.21 supports with training, and positive support services provided to an individual outside of
50.22 any service plan for a day program or residential support service.

50.23 (b) Component values for unit-based services with programming are:

50.24 (1) competitive workforce factor: 6.7 percent;

50.25 (2) supervisory span of control ratio: 11 percent;

50.26 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

50.27 (4) employee-related cost ratio: 23.6 percent;

50.28 (5) program plan support ratio: 15.5 percent;

50.29 (6) client programming and support ratio: 4.7 percent, updated as specified in subdivision
50.30 5b;

51.1 (7) general administrative support ratio: 13.25 percent;

51.2 (8) program-related expense ratio: 6.1 percent; and

51.3 (9) absence and utilization factor ratio: 3.9 percent.

51.4 (c) A unit of service for unit-based services with programming is 15 minutes.

51.5 (d) Payments for unit-based services with programming must be calculated as follows,
51.6 unless the services are reimbursed separately as part of a residential support services or day
51.7 program payment rate:

51.8 (1) determine the number of units of service to meet a recipient's needs;

51.9 (2) determine the appropriate hourly staff wage rates derived by the commissioner as
51.10 provided in subdivisions 5 and 5a;

51.11 (3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the
51.12 product of one plus the competitive workforce factor;

51.13 (4) for a recipient requiring customization for deaf and hard-of-hearing language
51.14 accessibility under subdivision 12, add the customization rate provided in subdivision 12
51.15 to the result of clause (3);

51.16 (5) multiply the number of direct staffing hours by the appropriate staff wage;

51.17 (6) multiply the number of direct staffing hours by the product of the supervisory span
51.18 of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

51.19 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
51.20 employee vacation, sick, and training allowance ratio. This is defined as the direct staffing
51.21 rate;

51.22 (8) for program plan support, multiply the result of clause (7) by one plus the program
51.23 plan support ratio;

51.24 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
51.25 employee-related cost ratio;

51.26 (10) for client programming and supports, multiply the result of clause (9) by one plus
51.27 the client programming and support ratio;

51.28 (11) this is the subtotal rate;

51.29 (12) sum the standard general administrative support ratio, the program-related expense
51.30 ratio, and the absence and utilization factor ratio;

52.1 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
52.2 total payment amount;

52.3 (14) for services provided in a shared manner, divide the total payment in clause (13)
52.4 as follows:

52.5 (i) for employment exploration services, divide by the number of service recipients, not
52.6 to exceed five;

52.7 (ii) for employment support services, divide by the number of service recipients, not to
52.8 exceed six;

52.9 (iii) for individualized home supports with training and individualized home supports
52.10 with family training, divide by the number of service recipients, not to exceed three; and

52.11 (iv) for night supervision, divide by the number of service recipients, not to exceed two;
52.12 and

52.13 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
52.14 to adjust for regional differences in the cost of providing services.

52.15 (e) Effective January 1, 2026, or upon federal approval, whichever is later, a provider
52.16 must not bill more than three consecutive hours and not more than six total hours per day
52.17 for individualized home supports with training and individualized home supports with family
52.18 training. This daily limit does not limit a person's use of other disability waiver services,
52.19 including individualized home supports, which may be provided on the same day by the
52.20 same provider providing individualized home supports with training or individualized home
52.21 supports with family training. This paragraph expires upon the effective date of paragraph
52.22 (f).

52.23 (f) Effective January 1, 2027, or upon federal approval, whichever is later, a provider
52.24 must not bill more than:

52.25 (1) for individualized home supports with training, a monthly service limit of 182.5
52.26 hours; and

52.27 (2) for individualized home supports with family training, not more than six total hours
52.28 per day.

52.29 The limits in clauses (1) and (2) do not limit a person's use of other disability waiver services,
52.30 including individualized home supports, which may be provided on the same day by the
52.31 same provider providing individualized home supports with training or individualized home

53.1 supports with family training or apply to individuals who meet the residential support
53.2 services criteria under sections 256B.092, subdivision 11a, and 256B.49, subdivision 29.

53.3 **EFFECTIVE DATE.** This section is effective the day following final enactment."

53.4 Page 225, delete section 29 and insert:

53.5 "Sec. .... **REPEALER.**

53.6 Subdivision 1. **Electronic visit verification provider requirements.** Minnesota Statutes
53.7 2024, section 256B.073, subdivision 4, is repealed.

53.8 Subd. 2. **MnCHOICES exceptions following an institutional stay.** Minnesota Statutes
53.9 2024, section 256B.0911, subdivision 21, is repealed.

53.10 **EFFECTIVE DATE.** Subdivision 1 is effective July 1, 2026. Subdivision 2 is effective
53.11 January 1, 2027."

53.12 Page 226, delete section 1

53.13 Page 229, delete section 5

53.14 Page 232, delete section 8

53.15 Page 234, delete section 9

53.16 Page 239, delete sections 10 and 11

53.17 Page 242, delete section 13

53.18 Page 242, line 27, delete "(122,988,000)" and insert "35,862,000"

53.19 Page 242, line 30, delete "(125,001,000)" and insert "33,849,000"

53.20 Page 242, line 33, delete "28,615,000" and insert "27,395,000"

53.21 Page 243, line 18, delete "$19,071,000" and insert "$18,756,000"

53.22 Page 243, line 19, delete "$16,954,000" and insert "$16,639,000"

53.23 Page 243, line 20, delete "1,795,000" and insert "24,795,000"

53.24 Page 243, line 22, delete "$2,195,000" and insert "$45,195,000"

53.25 Page 243, line 23, delete "$2,160,000" and insert "$45,160,000"

53.26 Page 243, line 26, delete "16,977,000" and insert "17,745,000"

53.27 Page 244, line 8, delete "$27,758,000" and insert "$28,665,000"

53.28 Page 244, line 9, delete "$28,498,000" and insert "$29,405,000"

54.1 Page 244, line 22, delete "39,695,000" and insert "39,721,000"

54.2 Page 244, line 26, delete "37,682,000" and insert "37,708,000"

54.3 Page 244, line 31, delete "$38,431,000" and insert "$38,457,000"

54.4 Page 244, line 32, delete "$38,431,000" and insert "$38,457,000"

54.5 Page 245, line 6, delete "(202,368,000)" and insert "(64,971,000)"

54.6 Page 245, line 8, delete "(156,000)" and insert "(141,000)"

54.7 Page 245, line 10, delete "(19,237,000)" and insert "(19,248,000)"

54.8 Page 245, after line 10, insert:

54.9 54.10 "Sec. 12. **GRANT PROGRAMS; HOUSING GRANTS**	**$**	**-0-**	**$**	**192,000**
54.11 54.12 Sec. 13. **GRANT PROGRAMS; ADULT MENTAL HEALTH GRANTS**	**$**	**-0-**	**$**	**(1,317,000)**
54.13 54.14 Sec. 14. **GRANT PROGRAMS; CHILD MENTAL HEALTH GRANTS**	**$**	**-0-**	**$**	**361,000**
54.15 54.16 Sec. 15. **GRANT PROGRAMS; SUBSTANCE USE DISORDER GRANTS**	**$**	**-0-**	**$**	**(361,000)**

54.17 Sec. 16. Laws 2024, chapter 125, article 8, section 2, subdivision 4, is amended to read:

54.18 54.19 Subd. 4. **Central Office; Aging and Disability Services**	(2,664,000)	4,164,000

54.20 (a) **Tribal Vulnerable Adult and**
54.21 **Developmental Disabilities Targeted Case**
54.22 **Management Medical Assistance Benefit.**
54.23 $200,000 in fiscal year 2025 is for a contract
54.24 to develop a Tribal vulnerable adult and
54.25 developmental disabilities targeted case
54.26 management medical assistance benefit under
54.27 Minnesota Statutes, section 256B.0924. This
54.28 is a onetime appropriation. Notwithstanding
54.29 Minnesota Statutes, section 16A.28,
54.30 subdivision 3, this appropriation is available
54.31 until June 30, 2027.

54.32 (b) **Disability Services Person-Centered**
54.33 **Engagement and Navigation Study.**

55.1 $600,000 in fiscal year 2025 is for the
55.2 disability services person-centered engagement
55.3 and navigation study. This is a onetime
55.4 appropriation. Notwithstanding Minnesota
55.5 Statutes, section 16A.28, subdivision 3, this
55.6 appropriation is available until June 30, 2026.

55.7 (c) **Pediatric Hospital-to-Home Transition**
55.8 **Pilot Program Administration.** $300,000 in
55.9 fiscal year 2025 is for a contract related to the
55.10 pediatric hospital-to-home transition pilot
55.11 program. This is a onetime appropriation.
55.12 Notwithstanding Minnesota Statutes, section
55.13 16A.28, subdivision 3, this appropriation is
55.14 available until June 30, ~~2027~~ <u>2028</u>.

55.15 (d) **Reimbursement for Community-First**
55.16 **Services and Supports Workers Report.**
55.17 $250,000 in fiscal year 2025 is for a contract
55.18 related to the reimbursement for
55.19 community-first services and supports workers
55.20 report. This is a onetime appropriation.
55.21 Notwithstanding Minnesota Statutes, section
55.22 16A.28, subdivision 3, this appropriation is
55.23 available until June 30, 2026.

55.24 (e) **Carryforward Authority.**
55.25 Notwithstanding Minnesota Statutes, section
55.26 16A.28, subdivision 3, $758,000 in fiscal year
55.27 2025 is available until June 30, 2026, and
55.28 $2,687,000 in fiscal year 2025 is available
55.29 until June 30, 2027.

55.30 (f) **Base Level Adjustment.** The general fund
55.31 base is increased by $340,000 in fiscal year
55.32 2026 and increased by $340,000 in fiscal year
55.33 2027.

56.1 Sec. 17. Laws 2024, chapter 125, article 8, section 2, subdivision 14, as amended by Laws
56.2 2025, First Special Session chapter 9, article 12, section 29, is amended to read:

56.3 Subd. 14. **Grant Programs; Disabilities Grants** 1,650,000 9,574,000

56.4 (a) **Capital Improvement for Accessibility.**
56.5 $400,000 in fiscal year 2025 is for a payment
56.6 to Anoka County to make capital
56.7 improvements to existing space in the Anoka
56.8 County Human Services building in the city
56.9 of Blaine, including making bathrooms fully
56.10 compliant with the Americans with Disabilities
56.11 Act with adult changing tables and ensuring
56.12 barrier-free access for the purposes of
56.13 improving and expanding the services an
56.14 existing building tenant can provide to adults
56.15 with developmental disabilities. This is a
56.16 onetime appropriation.

56.17 (b) **Dakota County Disability Services**
56.18 **Workforce Shortage Pilot Project.** $500,000
56.19 in fiscal year 2025 is for a grant to Dakota
56.20 County for innovative solutions to the
56.21 disability services workforce shortage. Up to
56.22 $250,000 of this amount must be used to
56.23 develop and test an online application for
56.24 matching requests for services from people
56.25 with disabilities to available staff, and up to
56.26 $250,000 of this amount must be used to
56.27 develop a communities-for-all program that
56.28 engages businesses, community organizations,
56.29 neighbors, and informal support systems to
56.30 promote community inclusion of people with
56.31 disabilities. By October 1, 2026, the
56.32 commissioner shall report the outcomes and
56.33 recommendations of these pilot projects to the
56.34 chairs and ranking minority members of the
56.35 legislative committees with jurisdiction over

57.1 human services finance and policy. This is a
57.2 onetime appropriation. Notwithstanding
57.3 Minnesota Statutes, section 16A.28,
57.4 subdivision 3, this appropriation is available
57.5 until June 30, 2027.

57.6 (c) **Pediatric Hospital-to-Home Transition**
57.7 **Pilot Program.** $1,040,000 in fiscal year 2025
57.8 is for the pediatric hospital-to-home pilot
57.9 program. This is a onetime appropriation.
57.10 Notwithstanding Minnesota Statutes, section
57.11 16A.28, subdivision 3, this appropriation is
57.12 available until June 30, ~~2027~~ 2028.

57.13 (d) **Artists With Disabilities Support.**
57.14 $690,000 in fiscal year 2025 is for a payment
57.15 to a nonprofit organization licensed under
57.16 Minnesota Statutes, chapter 245D, located on
57.17 Minnehaha Avenue West in Saint Paul, and
57.18 that supports artists with disabilities in creating
57.19 visual and performing art that challenges
57.20 society's views of persons with disabilities.
57.21 This is a onetime appropriation.
57.22 Notwithstanding Minnesota Statutes, section
57.23 16A.28, subdivision 3, this appropriation is
57.24 available until June 30, 2027.

57.25 (e) **Emergency Relief Grants for Rural**
57.26 **EIDBI Providers.** $600,000 in fiscal year
57.27 2025 is for emergency relief grants for EIDBI
57.28 providers. This is a onetime appropriation.
57.29 Notwithstanding Minnesota Statutes, section
57.30 16A.28, subdivision 3, this appropriation is
57.31 available until June 30, 2027.

57.32 (f) **Self-Advocacy Grants for Persons with**
57.33 **Intellectual and Developmental Disabilities.**
57.34 $250,000 in fiscal year 2025 is for
57.35 self-advocacy grants under Minnesota Statutes,

58.1 section 256.477, subdivision 1, paragraph (a),
58.2 clauses (5) to (7), and for administrative costs.
58.3 This is a onetime appropriation and is
58.4 available until June 30, 2027.

58.5 (g) **Electronic Visit Verification**
58.6 **Implementation Grants.** $864,000 in fiscal
58.7 year 2025 is for electronic visit verification
58.8 implementation grants. This is a onetime
58.9 appropriation. Notwithstanding Minnesota
58.10 Statutes, section 16A.28, subdivision 3, this
58.11 appropriation is available until June 30, 2027.

58.12 (h) **Aging and Disability Services for**
58.13 **Immigrant and Refugee Communities.**
58.14 $250,000 in fiscal year 2025 is for a payment
58.15 to SEWA-AIFW to address aging, disability,
58.16 and mental health needs for immigrant and
58.17 refugee communities. This is a onetime
58.18 appropriation and is available until June 30,
58.19 2027.

58.20 (i) **License Transition Support for Small**
58.21 **Disability Waiver Providers.** $3,150,000 in
58.22 fiscal year 2025 is for license transition
58.23 payments to small disability waiver providers.
58.24 This is a onetime appropriation.
58.25 Notwithstanding Minnesota Statutes, section
58.26 16A.28, subdivision 3, this appropriation is
58.27 available until June 30, 2027.

58.28 (j) **Own home services provider**
58.29 **capacity-building grants.** $1,519,000 in fiscal
58.30 year 2025 is for the own home services
58.31 provider capacity-building grant program.
58.32 Notwithstanding Minnesota Statutes, section
58.33 16A.28, subdivision 3, this appropriation is
58.34 available until June 30, 2027. This is a onetime
58.35 appropriation.

59.1 (k) **Continuation of Centers for**
59.2 **Independent Living HCBS Access Grants.**
59.3 $311,000 in fiscal year 2024 is for continued
59.4 funding of grants awarded under Laws 2021,
59.5 First Special Session chapter 7, article 17,
59.6 section 19, as amended by Laws 2022, chapter
59.7 98, article 15, section 15. This is a onetime
59.8 appropriation and is available until June 30,
59.9 2025.

59.10 (l) **Base Level Adjustment.** The general fund
59.11 base is increased by $811,000 in fiscal year
59.12 2026 and increased by $811,000 in fiscal year
59.13 2027.

59.14 Sec. 18. **APPROPRIATIONS GIVEN EFFECT ONCE.**

59.15 If an appropriation or transfer in this article is enacted more than once during the 2026
59.16 regular session, the appropriation or transfer must be given effect once.

59.17 Sec. 19. **EXPIRATION OF UNCODIFIED LANGUAGE.**

59.18 All uncodified language contained in this article expires on June 30, 2027, unless a
59.19 different expiration date is explicit."

59.20 Page 245, after line 25, insert:

59.21 "Sec. .... **COMMISSIONER OF HEALTH;**
59.22 **TOTAL APPROPRIATION** **$** **-0-** **$** **1,125,000**

59.23 The amounts that may be spent for each
59.24 purpose are specified in the following sections.

59.25 Sec. .... **HEALTH IMPROVEMENT** **$** **-0-** **$** **1,125,000**"

59.26 Page 245, delete section 2

59.27 Page 246, after line 8, insert:

59.28 "Sec. .... **APPROPRIATIONS GIVEN EFFECT ONCE.**

59.29 If an appropriation or transfer in this article is enacted more than once during the 2026
59.30 regular session, the appropriation or transfer must be given effect once.

60.1 Sec. .... **EXPIRATION OF UNCODIFIED LANGUAGE.**

60.2 All uncodified language contained in this article expires on June 30, 2027, unless a
60.3 different expiration date is explicit."

60.4 Renumber the articles and sections in sequence and correct the internal references

60.5 Amend the title accordingly

60.6 Adjust amounts accordingly